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2011-2012 Annual Report

South East Local Health Integration Network

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Board of Directors

Wynn Turner (Chair)
Appointed: 1 November 2009
Term Expires: 31 October 2012

Andreas von Cramon (Acting Vice-Chair)
First Appointed: 28 April 2010
Term Expires: 28 March 2013

Arthur Ronald
First Appointed: 10 August 2010
Term Expires: 10 July 2013

Ian Fraser
First Appointed: 15 September 2010
Term Expires: 14 September 2013

Dave Sansom
First Appointed: 4 May 2011
Term Expires: 4 May 2014

Jyoti Kotecha
First Appointed: 24 March 2010
Term Expires: 24 February 2013

Georgina Thompson (Past Chair)
Appointed: 9 June 2008
Term Expired: 8 June 2011

John Ferguson
Appointed: 19 June 2008
Term Expired: 19 June 2011

Leslie Benecki
First Appointed: 8 October 2008
Term Expired: 7 October 2011

Senior Executive

Paul Huras
Chief Executive Officer

Sherry Kennedy
Chief Operating Officer

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Message from the Board Chair

On behalf of the Board of Directors of the South East Local Health Integration Network, I am pleased to provide our 2011-2012 Annual Report.

Since assuming the role of Acting Chair in June of 2011, and subsequently being confirmed as Chair earlier this year, I have come to appreciate even more fully the work we have done and the accomplishments we have achieved. I am also immensely grateful for the support and encouragement I have received from my fellow Board members, our CEO, and the dedicated team of LHIN staff specialists who work so hard on behalf of residents across our region.

I also want to thank the executive and staff of the Health Service Provider partners across our region for their spirit of cooperation, their commitment to their respective jurisdictions and their determination to work, together, to provide the highest-quality of health care for the nearly 500,000 people who live and work in southeastern Ontario.

Wynn Turner

Chair, South East LHIN Board of Directors

Message from the CEO

I join our Board Chair in expressing my gratitude as we submit our 2011-2012 Annual Report for the South East LHIN.

This has been yet another year in which we have witnessed profound and remarkable change. And while we all acknowledge that change may be the only constant in life, we must also recognize that it is the primal force by which true progress is made.

Here at the South East LHIN we continue to effect change that is informed and guided by the needs of our residents; manifested in the systems improvements implemented by our Health Service Provider partners; and aligned with the overall provincial priorities shared by the Ministry of Health and Long Term Care.

Through it all, I am struck by the singularity of purpose that compels change; by the results it can achieve; and also by the compassion with which it accommodates those who are affected by it and who – even more importantly – benefit from it.

To our Board members whose collective wisdom guides our governance; to our LHIN staff whose hard work and dedication accomplish so much; and to our Health Service Provider partners whose expertise and experience deliver the best in quality care to our residents – I offer my sincerest appreciation for their continuing excellence.

Paul Huras, CEO

South East LHIN

Overview

FACTS & FIGURES

Population *(2012)* –

FUNDING *(Allocated to Health Service Providers - 2011/12)* **$1,070,700,326**

Providers

7 Hospitals operating 11 Sites
1 Community Care Access Centre (South East)
37 Long Term Care Homes

Community Agencies

34 Community Support Service agencies
3 Acquired Brain Injury (ABI) Programs
3 Assisted Living/Supportive Housing Programs
8 Addictions Program agencies
5 Community Health Centres
16 Mental Health Program agencies

Funding by Sector (2011/12)

Operation of Hospitals	$703,298,709
Municipal Tax Grants – hospitals	$ 190,725
Long Term Care Homes	$170,862,498
Community Care Access Centre	$102,084,846
Community Support Services	$ 31,165,261
Community Health Centres	$ 22,200,869
Community Mental Health	$ 34,365,874
Addictions Program	$ 6,531,544
Total Funding Allocated	**$1,070,700,326**

Percentage Funding by Sector – 2011/12

Operation of Hospitals	65.7%
Municipal Tax Grants – hospitals	0.02%
Long Term Care Homes	16.0%
Community Care Access Centre	9.5%
Community Support Services	2.9%
Community Health Centres	2.1%
Community Mental Health & Addictions Programs	3.8%

Community Overview

At 19,473 square kilometers, the South East LHIN is the fourth largest local health integration network by geographic area. We serve approximately 3.8% of Ontarians who live, in almost equal proportion, along a ribbon of more urban areas following Highway 401, or in small rural communities located across the remainder of the area.

The LHIN geographic area includes the communities bounded by towns of Brighton and Cardinal from east to west, and from Prince Edward County to just north of Lake St Peter from north to south. LHIN geographic areas were determined based on where residents primarily received their care. 98% of all South East LHIN residents obtain care from local health service providers.

Accountability and responsible health system management

LHINs were developed with accountability as a core value. *The Local Health System Integration Act, 2006* specifies the powers of the LHIN Board to make decisions regarding the local health system, within the provisions of the *Act* and under the stewardship of the Ministry of Health and Long-Term Care. The LHIN is required to engage in consultations with its communities as part of its strategic planning and priority setting cycles. Decisions of the LHIN must be made in full consideration of the public interest.

Every three years, LHINs develop their Integrated Health Service Plan (IHSP) – which defines our strategic objectives for the local health system. The IHSP provides a framework for the LHIN and our health service providers to ensure that time, effort and resources are appropriately aligned.

Each LHIN has a Performance Agreement between itself and the Minister of Health and Long-Term Care. That agreement specifies the obligations of both parties, as well as identifies areas where the ministry wants to see improvement. Performance indicators, along with multi-year targets, are set out in this agreement, and the results are reported publicly, through this report and other channels.

As a Crown Agency, the LHIN is fully responsible for following Directives from the Province of Ontario regarding allocation of funding, operational spending, tendering for third party services, hiring, and other policies that are directed towards Ontario's agencies, boards and commissions.

The Chief Executive Officer of each LHIN has quarterly meetings with senior ministry officials to brief them on the impact of the LHIN's activities, highlighting successes as well as opportunities for greater improvement.

The LHIN Board of Directors has ultimate accountability to the Minister of Health and Long-Term Care. All major decisions taken by the LHIN are directed by our Board. Our CEO provides monthly updates on operational activities, reports on performance indicator results, and provides updates on our progress towards achieving our IHSP priorities.

Within this accountability framework, the South East LHIN Board has set in place four corporate strategic goals:

To build a true system of integrated health care that optimizes the use of resources

To build understanding of the role of the SE LHIN in developing and managing a regional system of integrated patient-centred care

To build a functional integrated e-health system that supports better health care services and healthier citizens

To demonstrate leadership as a knowledge–based organization that is credible, professional, proactive and responsive.

LHIN Board members, executive, and staff are fully briefed on our accountability relationships and are required to incorporate the requirements contained in them into their relationships with our HSPs, as well as into their work activities.

As important and necessary as these formal accountabilities are, they do not directly speak to our most important accountability – to the residents who live within our geographic area.

The Board and staff of the South East LHIN are also residents of this community. We share the vision of an accessible and sustainable health care system expressed by residents.

Being accountable is more than reporting the right numbers. In the South East LHIN, it means making decisions that will have positive impact on the quality and sustainability of the health system. It means making things work better, and doing what makes sense.

Meeting provincial standards

The South East LHIN has worked diligently with its health service providers to ensure that provincial standards of care are met by addressing local health-care needs. We have been innovative so that our engagement with our communities was significant and meaningful, allowing us to develop an approach that reflected community input. We have looked beyond Ontario's borders to find models, programs and processes that have been proven to provide services more efficiently and effectively, or which help people avoid typical — but preventable —reasons for accessing the health care system. Our objective is to enhance and evolve the local health care system to ensure it meets, and continues to meet, the needs of our residents.

Major accountability projects

As part of our mandate, the South East LHIN has undertaken a number of projects that support our accountability relationships, priorities for change at a health systems level, or improve our overall understanding of the local health care system. In 2011/12, the LHIN engaged in several projects of this type.

South East Community Care Access Centre (CCAC) Performance Assurance Review (PAR)

One critically important aspect of the South East LHIN's commitment to ensuring that residents of this region have access to the support services they may require is our obligation to monitor the performance and efficiency of the Health Service Providers who are charged with the responsibility of delivering that support. In response to a number of concerns regarding the South East CCAC's ability to meet their clients' needs consistently and effectively, the SE LHIN enlisted the help of an independent management consulting group to conduct an objective review of that organization's strategic and operational performance.

The results of that performance (PAR) review led to changes in CCAC leadership and the implementing of an overall, ongoing, improvement plan that has yielded positive results. The South East CCAC is completing the final few initiatives as part of the implementation plan developed jointly with the SE LHIN. Successful implementation of changes in business intelligence and client services have allowed the South East CCAC to become a leader provincially in these areas and the SE LHIN is confident that the spread and sustainability of improved capacity will position the South East CCAC as a leader in the SE LHIN region.

Community Services Back Office Project

As part of our accountability agreements with community providers, each are participating in an exercise to determine what core administrative services could be combined and shared through a common 'back office'. The intent of the project is to determine how much could be saved by the system by, for example, having a single payroll system, or a common bookkeeping office. Phase I of this project, which involved an assessment of what back office services could be shared, was completed in 2009/10.

Phase II, the development of options for a back office approach culminated in the Fall of 2010 with the SE LHIN Board approving the implementation of initiatives such as a common purchasing plan, models for transactional accounting services, and a shared benefits plan.

Phase III, the implementation of these initiatives, is well underway with some initiatives already fully operational. Early indications are there have been some financial savings but the largest benefit has been increased capacity within the community sectors allowing agencies to provide more front line care to clients and patients.

Shared Support Services of Southeastern Ontario (3SO)

Similar in nature to the Back Office Project, 3SO is a collaboration of the South East LHIN hospitals to create a shared back office for purchasing and procurement services. 3SO, employing staff who are expert in procurement, leverage the purchasing power of all the hospitals, allowing hospital management to direct their attention to their core business of providing excellent patient care.

Long-Term Care Home Service Accountability Agreements (L-SAAs)

With the enactment of the *Local Health System Integration Act, (LHSIA)* in 2006, the LHINs assumed full responsibility for planning, funding and integrating health services in their geographic areas.

In fulfilling that responsibility, they began the negotiation of service accountability agreements (SAAs) between themselves and the health service providers (HSPs) they funded. In accordance with the timetable set out in *LHSIA,* Hospital SAAs (H-SAAs) were negotiated for 2008-10. Multi-sector SAAs (M-SAAs) were negotiated with community support services agencies, community care access centres, community health centres and community mental health and addictions agencies for 2009-11.

In 2010, the SE LHIN successfully negotiated Long-Term Care Home (LTCH) Service Accountability Agreements (L-SAAs) with 37 Long-Term Care Homes in the south east.

The L-SAAs represent important changes for the Long-Term Care Home (LTCH) sector and for the LHINs. They focus on accountability and performance and are an integral component to the ongoing effort to improve health system performance and provide high-quality, resident-centered care. They also emphasize the important, collaborative role the sector plays in enhancing the stability and accountability of our health care system, and support the alignment of health services across the various sectors.

Report on IHSP2

The second Integrated Health Services Plan (IHSP2) for the South East LHIN was completed in 2009. It builds upon the progress made to improve local health care since the first IHSP was approved in October 2006.

In preparing this plan, we conducted extensive research on the health of our residents to find out what health care services they used. We talked to Ontarians who live in the

communities we serve to gain their views about the local health care system. We asked what was good about health-care locally and what could use improvement. We also asked what the future local health-care system should look like. Finally, we consulted with our providers to gain their perspective of the local health-system's strengths, opportunities for improvement and generally how well they saw the system meeting people's needs.

The outcome of this research was IHSP2, and the Ten Priorities that will direct the LHIN's activities from 2010/11 through 2012/13. A full copy of IHSP2 is available at www.SouthEastLHIN.on.ca

We are very proud of the accomplishments that our health service providers have made, and that we have achieved collectively over the past four years. The results speak to the dedication and commitment of every health-care provider in this LHIN, as well as to all the administrative, operations, and support people behind them.

One of the concerns raised in health-care is that there is so much change, people just can't keep up. We think our results tell a different story. Change for the sake of change is not sustainable. However, change that fits with a vision of success *is* sustainable. Change linked to a clearly articulated goal, with a way to measure progress towards that goal, can energize people.

There is nothing stagnant about health-care. Medical discoveries have not slowed down over the last 20 years. Surgical residents today are not learning the same techniques and approaches that their teachers learned. Everything in health-care is changing all the time. The LHIN's role is to ensure that change is focused on what is important to the health-care needs of our residents now and in the future.

IHSP2 told us that the system was, largely speaking, doing what it was supposed to do. Our job in IHSP2 was not to create a new local health-care system, but to 'renovate' the existing one.

In all, there are ten priorities set out in IHSP2 to assist the South East LHIN in creating an accessible and sustainable system for care. In turn, these priorities will also position care so that it is provided in the right place at the right time. These system improvements will enable the acute care system to be better able to focus on its role.

Our report on IHSP2 is listed by each of the ten priorities identified in it, and a summary of key activities supporting those priorities.

1. Developing a System of Primary Health Care

Access to Primary Care has been identified as an immediate priority in IHSP2 since it deals with most health problems encountered by most people most of the time and is often the main entry point into the healthcare system. As such, Primary Care must be accessible whenever health needs arise; it must focus on individuals over the long term; and it must offer comprehensive care for all health problems.

Activities supporting this priority

Health Care Connect: Healthcare connect is a provincial service, conceived and developed in the South East LHIN, that provides a means for Ontarians to obtain a primary health care practitioner without having to canvass all local Physicians.

In 2007, approximately 80% of Ontarians living in the South East LHIN did not have a primary health care provider. As of March 31st, 2012, 98% of those who wanted a primary health care provider had been referred to one – the third-highest such rate in the province.

Memorandum Supporting Collaboration: On October 31st, 2011 the South East LHIN Board and representatives from ten regional Family Health Teams (FHTs) and one Family Health Organization (FHO) signed a "Memorandum Supporting Collaboration" (MSC) designed to improve cooperative planning between the LHIN and these primary care groups – giving family doctors who work with them a greater say in what services should be provided to meet their patients' needs.

Because the majority of physicians in Ontario are funded directly by the Ministry of Health and Long-Term Care, there had been no requirement for any formal collaboration between the FHTs (or the primary care family doctors who work with them) and the LHIN. Over the prior year, however, the South East LHIN made the case for closer collaboration between the FHT primary care physicians – who assess and prescribe services for their patients – and the LHIN, which funds the providers who deliver those services.

During this time, executive directors of the family health teams and their physician leads have worked with the South East LHIN to develop this MSC that recognizes the need for both parties to seek better ways of aligning their priorities so that patients can benefit from improved access to care.

The MSC outlines ways in which the LHIN and FHTs can work more closely together in order to:

- Make the local health system more responsive by ensuring that services prescribed by family doctors are available to their patients when needed.
- Improve overall future planning through the sharing of information between the LHIN and FHTs, including identifying service bottlenecks, and finding solutions to them.
- Cooperatively drive improvement in the health system through actual experience and best practice.

Primary Health-Care Council: The South East LHIN, in conjunction with Queen's FHT, established our Primary Health Care Council two years ago. The Council is charged with the responsibility of advising the LHIN on how best to build a system of primary care. It is comprised of primary care providers from across the LHIN. In April, 2012 the Council hosted the fourth Annual Primary Health Care Forum, providing an opportunity for researchers, policy decision makers and members of the primary health care community to meet and discuss areas of mutual interest.

Appointment of Primary Care Lead by South East LHIN: And finally, but by no means least, on February 3, 2012 the South East LHIN took a major step in strengthening and further integrating primary care into local health planning by naming Dr. Jonathan Kerr as the Primary Care Lead for the SE LHIN. This step aligns with similar appointments in each of the province's 14 LHINs and is endorsed by both MOHLTC and the Ontario Medical Association. It is also in line with the government's Action Plan commitment to bring planning for the full patient journey under the LHINs.

2. Enhancing a Culture of Patient-Centred Care

The need for patient-centred care is commonly expressed by the public as an expectation of our health-care system. Patient centred or patient directed care includes good "customer" service, access and responsiveness. It also includes assistance in navigating and coordinating the many components of care or treatment a patient may require to maintain or improve health. Patient centred care is about quality service and quality care, where the needs of the patient and the population drive the utilization and deployment of resources. Within the South East LHIN, a culture of patient centred care must be fostered to ensure our system is integrated and appropriately responds to the needs of the individual and the population.

Activities Supporting this Priority

Wait List Management: The South East LHIN has maintained the requirement of hospitals providing services funded under Ontario's Wait Time Strategy to audit their wait lists to ensure that anyone waiting longer than 180 days was reassessed.

Directed funding: The LHIN re-allocated funding within the fiscal year to ensure hospitals that could perform more surgeries had the resources to provide them.

Excellent Care for All Act (ECFAA): Since this Act came into effect in July, 2010, the South East LHIN has been active in educating and promoting to our HSPs the spirit and requirements of the legislation; and assisting our Hospitals with the review and completion of their Quality Improvement Plans (QIPs).

Senior-Friendly Hospitals: The *"Senior-Friendly Hospital"* philosophy introduced in 2010 has found expression in the SE LHIN's Clinical Services Roadmap initiative where elements have been incorporated into the Clinical Work Plans developed for the *Emergency Department Wait Times* and *Restorative Care* areas of clinical opportunity.

Improved coordination of care: Work done as part of our *Aging at Home* strategy has improved the dialogue and cooperation between hospital discharge planners, CCAC case coordinators, and community service support case coordinators within the LHIN. Over the last four years, an increase of 45% in referrals to CSS agencies has been noted.

3. Improving Mental Health and Addictions Services Capacity

In keeping with the planned development of the 10-year strategy on Mental Health and Addictions for the province, the South East LHIN will focus its efforts on integrating mental health and addictions services across the levels of care and with the main health-care system. Our efforts will focus on early identification and intervention in a seamless system of comprehensive, effective, efficient, proactive and population-based services and supports by revaluating current resources.

Activities Supporting this Priority

Behavioural Support Services: In August, 2011 the South East LHIN was chosen as one of four early-adopter LHINs to implement the Behavioural Supports Ontario (BSO) project, investing $2.42 million to enhance services for seniors who exhibit behaviours

associated with complex and challenging mental health, dementia or other neurological conditions. As part of a $40 million provincial investment through all 14 LHINs across Ontario, this support allowed local health service providers in the south east to hire new staff – nurses, personal support workers and other health care providers – and train them in the specialized skills necessary to provide care that will enable these patients to live with dignity and respect.

The initial phase focused on residents of Long Term Care Homes by establishing Mobile Response Teams (MRTs) at three geographic sites, including Hastings Prince Edward, Frontenac Lennox-Addington and Lanark Leeds Grenville.

The Behavioural Support Services investment focuses on providing quality care for individuals with these conditions, in an environment that is based on safety, high-quality, evidence-based care and practice.

The Behavioural Supports Ontario (BSO) project is a collaboration between Local Health Integration Networks, the Alzheimer Society of Ontario, Health Quality Ontario, and the Ministry of Health and Long-Term Care.

4. Developing Regional Program Management

Residents of Southeastern Ontario express a need for improved access. What they often mean is enhancing capacity or providing more service. Access can be improved, capacity enhanced and service increased through better system management of our current regional resources. This is the concept of getting more from what is available. Regional program management is about managing health services, which may currently be managed separately in two or more sites across our region, as one program. It includes services that are delivered in multiple sites and are integrated across the region depending on volumes and availability of resources.

Regional program management would allow for a clinical and administrative lead to facilitate the development of a common vision and targets, thus improving accountability for service performance across the region.

Activities Supporting this Priority

The South East LHIN Regional Clinical Services Roadmap: As the catalyst to achieving a truly regionalized system of integrated health care the Regional Clinical Services Roadmap (CSR) has been the mainstay of the SE LHIN's strategic plan throughout this past year.

In collaboration with our seven hospitals and the CCAC, the SE LHIN undertook a broad-based planning initiative to address the most pressing issue in health care in Ontario and Canada – ensuring that the local health system provides each and every resident with the right care, at the right time, in the right place.

Conceived and developed on the driving principles of sustainability, access, efficiency and quality, the Clinical Services Roadmap has the ongoing collective support of the South East CCAC and Hospital Executives Forum (SECHEF) as well as the support of the SE LHIN, hospitals, and CCAC Board Chairs. Since the launch of the Roadmap in July, 2010, all Boards have been fully briefed twice on the progress and goals of this initiative. Additionally, in late 2010, the hospital and CCAC Board Chairs all signed a charter of support for the Roadmap.

Through the involvement of our Knowledge Management team – and with the insights provided by their highly-acclaimed report on the *Regional Analysis of SE LHIN Hospital Services* – the SE LHIN thoroughly investigated the current and projected health care needs of our residents. As part of this analysis, we worked with our partners to identify areas where the investment of time and energy of our front line doctors and clinicians would provide the greatest gains for our residents. Careful review and consultation identified seven clinical "areas of opportunity" including Cardiac Care, Surgical Services, Mental Health and Addiction Services, Restorative Care, Emergency Department Wait Times, Maternal and High Risk Newborn Care, and Hospital Acquired Infections (HAI).

Beginning with the launch of the CSR in July 2010, individual Clinical Work Teams comprised of doctors, nurses, clinicians and SE LHIN administrative leads developed Clinical Work Plans specific to each of these areas of opportunity. Those work plans were the focus of a region-wide Community Engagement process that was launched in March, 2011 to capture input and opinion from residents who were encouraged to participate online where they were asked to complete and submit workbooks for each clinical area.

Out of this process of gaining public input, themes were identified and incorporated into the final work plans which were then given final approval from SECHEF and the hospital/CCAC Boards during the fall of 2011. Planning and organization for the implementation of these work plans began in the Spring of 2012 and will unfold over the next one to three years.

Community Engagement

In October, 2011 the SE LHIN Board approved the LHIN's first-ever formal Communications & Community Engagement Plan that set out a schedule of engagement activities and desired, measurable, results. The plan provides a solid basis upon which the LHIN can ensure that it will succeed in soliciting, gathering and incorporating meaningful input and comment from residents of the south east region into the strategic and operational direction to be pursued on their behalf.

5. ***Improving Access to Emergency Rooms***

Emergency Departments are seen as the "canaries in the mine" of the health-care system. That means if something is not right with the local health system, it is often exposed from one's experience in the emergency room. When appropriate access to and flow through an emergency room is timely and successful, the public is confident that the health system is functioning well. A truly integrated health-care system makes the most effective use of the emergency rooms. We have an opportunity to improve access to and from the emergency room. All LHINs view this as an essential priority for change.

6. ***Reducing the Incidence and Prevalence of Alternate Level of Care***

When someone is placed into an acute care bed who does not need acute care or someone stays in an acute care bed when they no longer require acute care, the patient and the system are both compromised. The patient may lose strength or acquire an infection and the system loses or misuses valuable capacity. All patients should be appropriately placed in the setting that best fits their care needs.

Note: Given the ways in which our priorities of "Improving Access in Emergency Rooms" and "Reducing the Incidence and Prevalence of Alternate Level of Care" are inextricably linked, and govern so much of what we do across the South East region, we offer the following synopsis of how these two priorities are addressed within the South East LHIN.

Understanding the Emergency Department-Alternate Level of Care Relationship

On the surface, the connection between Emergency Department volumes and how patients are discharged from hospital is quite straightforward. Assuming full occupancy, for every new patient to be admitted another patient needs to be discharged. When the SE LHIN started to consider this problem, we became more

interested in knowing about the patients who were coming to the ED, why they were being admitted and why they had trouble going home after their hospital care had ended.

The SE LHIN used known demographics, clinical data, and information provided by front line staff to develop a profile of the type of patient most likely to arrive at the Emergency Department; be admitted to a ward in the hospital (even though their condition was not immediately life threatening); and subsequently very likely to be referred for placement in a long-term care home.

Our research showed that this typical ED/Alternate Level of Care (ALC) patient would likely be:

Over the age of 75

Living alone, or acting as the primary caregiver for a spouse who could not take care of him/herself

Someone who had recently experienced the death of a spouse, loved-one, or primary caregiver

Someone who had been diagnosed as having at least one chronic disease (such as congestive heart failure, diabetes, etc.)

Someone who had experienced a recent change in health status

Each of these characteristics speaks to a single event or combination of factors that can render a senior unable to cope with their daily living circumstances.
Once that happens, any adverse event – such as slipping and falling or becoming dehydrated – will likely result in a trip to the Emergency Department.

The South East LHIN ER/ALC Strategy

Our strategy addresses the circumstances that bring patients to emergency departments, and the chain of events that can occur if there is no concerted effort to return a client home with appropriate support.

Three main areas are addressed by the strategy:

Business Process Redesign: where we considered operational improvements that will reduce miscommunication, delays in processing and errors than might lead to duplication of effort.

Management of Clients' Needs: by ensuring that waiting lists for appropriate care were established. Setting target times by which services had to be delivered ensured patients received care at the right time.

Identifying Physical Resources: where reviewing case presentations, along with the data, helped us identify the resources needed to avoid ED visits in the first place, and help patients go home as soon after their hospital stay as possible.

Inability to Manage Activities of Daily Living

Thanks to the SMILE (*Seniors Managing Independent Living Easily)* program, *Easier +,* and other collaborative efforts through the CCAC and CSS, a web of care has been created for seniors to help them manage their ADL (*Activities of Daily Living).* These services are provided in an effort to avoid repeat ED visits and are meant to hasten their discharge from hospital.

Trigger Events

The early identification of frail-elderly patients by ED staff who observe their arrival and progress can lead to a referral and an assessment for the kind of community home support services those patients may need. This review of early ALC designation also helps in identifying additional process improvements that may be required within the LTCH sector to reduce repeat ED visits and have patients discharged from hospital as early as possible.

Emergency Department Visits – Capacity & Performance

Understanding the patient flow within an Emergency Department has helped the SE LHIN understand and improve upon our ED Wait Times.

The two largest EDs in our region received *Pay for Results* (P4R) funding in 2010/11. Although they have the longest ED wait times, we know they worked hard to reduce them. Kingston General Hospital, for example, had achieved patient flow improvements among their non-admitted patients and reductions in the time it takes to see a physician. Wait times for admitted patients (those patients who visit and ED and require hospitalization) however, are still above provincial targets.

2010/11 was the first year in which Quinte Health Care – Belleville, received P4R funding. They had put considerable effort into learning and adopting process improvements, and reducing patient flow barriers both within the ED and the inpatient unit. Initial findings noted that bed turnaround times (the time between when a discharged patient leaves a bed until the next time it's occupied) had also improved.

Hospital Admissions

Through an integrated discharge planning process, patients at high risk for needing ALC are being identified earlier to avoid the physical and cognitive decline that can accompany a lengthy hospital stay. This process also helps avoid inappropriate ALC designation or delays in discharge. Programs included in this planning process are *Home First,* and *Enhanced Activation Therapy.*

Acute Care ends – patient goes home

An important cultural paradigm shift has taken place throughout the SE LHIN – one that attempts to ensure every patient gets the opportunity to go home first, before any alternate care setting is discussed.

ED/ALC Initiatives to reduce ED visits

SMILE Program

SMILE *(Seniors Managing Independent Living Easily)* is a program unique to the SE LHIN. It enables seniors to live independently in their own homes by providing them with support services for household tasks they may not be able to perform for themselves, such as mowing a lawn or shopping for groceries. The SMILE Program coordinating agency provides these types of services that may be needed above and beyond those already provided by CCAC and CSS agencies. If there is no local provider available, SMILE will pay for these services to be provided by whoever the client wishes to employ. Since SMILE was launched over four years ago, the number of patients waiting for long-term care has dropped by 700.

ED Capacity and Performance

The LHIN's strategy to improve upon wait times is a combination of reducing reliance on EDs, as well as improving upon how well EDs operate.

Seeing and treating patients through alternative ED processes has significantly reduced the time patients have to wait to receive care. Patients waiting for admission to hospital from the Emergency Department, however, still have long waits before an inpatient bed can be made available for them.

Home First

The *Home First* philosophy enables frail seniors to return home following an acute-care hospital stay rather than being sent to an alternate level of care. It speaks to the cultural paradigm shift that sees many patients going home after their hospital care, whereas in the past they would have had to wait in hospital for a long-term care home bed to become available.

First launched at QHC in 2009/10, *Home First* has since been adopted at BGH and KGH. This has led to a gradual reduction in the number of patients being designated as requiring ALC over this past year. By improving hospital-to-community discharge processes and access to community services, the "Home First way" has seen a reduction in unnecessary hospitalization.

Furthermore, over half of those seniors who went home thanks to *Home First* are still in their homes. This has reduced the demand for long-term care home beds, which, in turn, will enable those who *do* need that level of care to get it sooner. This is borne out in the following results:

- As of November 2011, the South East LHIN reported 10.3% of all hospital inpatient days as ALC – a reduction of approximately 7% since 2006. For SE LHIN residents this has ensured that patient flow is improving and more patients are receiving the right care at the right time in the right place. For seniors residing in the South East, Home First has provided them the opportunity to go home after their acute event with appropriate community supports and services to remain at home as long as they desire.

- Since the adoption of Home First at Kingston General Hospital, over 100 clients have gone home where previously they would have remained in hospital waiting for LTCH placement, which was certainly not their preferred discharge destination.

- A recent 3 month Home First clients/caregiver survey informs us that :

1. 67% of Home First clients who went home felt the care they received in hospital prepared them for home
2. 91% were satisfied with the community support they were receiving at home
3. 62% rated themselves "excellent to good" in managing at-home, post-discharge, living
4. 77% feel their ability to manage at home is improved since they were discharged from hospital
5. 81% feel adequately supported at home
6. While no Home First clients are seeking urgently admission to LTCHs, 25% have their names on the waitlist.

- Home First clients are receiving CCAC services along with CSS services, an overall basket or services to ensure ADL and iADL (*Instrumental Activities of Daily Living)* are being provided. It is reported that 77% of HF contacted by CSS are taking services to assist with their desire to remain at home. Most clients request and received home delivered meals, homemaking and respite care for caregivers.

- In 2009 Kingston General Hospital typically had over 60 ALC clients at any given time. Today the average number of ALC clients has dropped to 25.

Discharge Link

Discharge Link was launched in February, 2009, to provide enhanced community-based rehabilitation services for stroke survivors at home and in long-term care homes. Services provided through this program include physiotherapy and access to occupational health and social workers. Initial evaluation has demonstrated a reduction in Length of Stay (LOS), fewer readmissions through Emergency Departments and overall better patient outcomes.

The *Discharge Link* model of care has been adopted for high-risk frail seniors who require intense rehabilitation therapy while in hospital to help them avoid decline. It also coordinates community services to ensure patients continue to strengthen or maintain their physical and cognitive abilities. Early stages of this *Enhanced Activation* program have already helped achieve a reduction in ALC as patients or their families are feeling "healthier and more able to manage at home."

The initiative has seen a significant reduction in LOS, and fast access to rehabilitative services in the community, including patient and hospital utilization outcomes such as:

- Visit rates have increased and in some cases (e.g., Occupational Therapy) more than doubled
- The range of visits per discipline has expanded up to **1-24** visits in 8-12 weeks
- Average wait time to access community rehab before enhanced service implementation was **44 days**, Since implementation the average wait time has decreased to **4.9 days**
- **15.7**-day decrease in mean total hospital length of stay
- FIM change scores remain stable
- Substantially improved Functional Capabilities and LOS Efficiencies
- Decreased readmission rates (avg. visits per follow up client within 1 year after index stroke event) for those who received enhanced service when discharged directly from acute care.

Home at Last: A simple solution for patients whose discharge from hospital may be delayed due to the lack of an appropriate home environment to which they can go, is to provide them with transportation home and help to get them settled by providing services such as grocery shopping, meal preparation or housekeeping services that are temporarily available through Community Support Services agencies.

Interestingly, over 57% of the clients who received these temporary *Home at Last* services went on to (and continue to) pay independently for help with their day-to-day living at home.

Overall, the South East LHIN's integrated ER/ALC strategy is intended to meet or exceed Ontario's targets for wait times and access, while meeting local health care needs. We are already seeing highly-positive results within just a few months of the launch of these various projects and programs described above. We expect even greater results going forward.

7. *Implementing the Ontario Diabetes Strategy*

Due to the high prevalence and impact of diabetes in this region, an essential first step into chronic disease management will be to focus on this serious disease. We have opportunities to integrate diabetes care and the monitoring of management indicators. Lessons learned will drive other chronic disease management strategies.

Activities Supporting this Priority

Alignment with the Ontario Diabetes Strategy: Diabetes is a serious chronic disease that is costly to the individual, their families and society alike. Patients living with diabetes are encouraged to self-manage their disease by making healthy lifestyle choices and by taking medication if needed.

Because of its complex nature, effective management of the disease and the avoidance of serious complications requires access to a range of health-care services. Patients with diabetes within the SE LHIN will benefit through improved health promotion, prevention, increased access to diabetes care and more coordinated services to help them manage the disease.

South East Diabetes Regional Coordination Centre (DRCC): The LHIN works in co-operation with the DRCC to ensure their strategies align with LHIN priorities. As the organization that helps to coordinate and improve diabetes services, the DRCC was launched in the South East in 2010, attached to the Community Health Centre in Merrickville. As one of 14 such centres across Ontario, and as part of the Ontario Diabetes Strategy, the goal of the SE LHIN DCCR is to help better organize and manage local diabetes programs and to improve the health and health outcomes for patients living with, or at high risk of developing, diabetes.

Diabetes Self-Management Initiative: Hosted by the Kingston CHC. The aim of the Ontario Diabetes Strategy Self-Management Initiative is to provide support, tools and expertise to foster self-management capability. This includes capacity building for service providers, communities and individual diabetics through: training and coaching/mentoring of multidisciplinary service providers to integrate self-management approaches into their practice; and training of Peer Leaders and Master Trainers to increase access to, and delivery of, Chronic Disease Self-Management Skill Building Group Programs for individuals with diabetes.

8. *Furthering Access Through E-health*

E-health is a key enabler to achieving an integrated system of care. E-health will ultimately produce an electronic health record, but will also advance the electronic transfer of diagnostic requests and results, standard referral protocols, timely communication between professionals, and rapid access to current research. The South East LHIN will advance its e-health strategy in coordination with the provincial e-health

strategy. E-health will lead and enable the diabetes strategy roll out. E-health will also lead and enable the regional surgical program e-referral initiative. Further, e-health will lead and enable initiatives to develop primary health care as a regional system of care.

Note: Since this priority was first identified as part of IHSP2 there has been a shift in direction in the overall Provincial Diabetes Strategy that has reduced the role of e-Health in the roll out of that strategy. All other aspects of the SE LHIIN's priority of "Furthering Access Through E-health" remain the same.

Activities Supporting this Priority

Regional Surgical eReferral: A Pilot Project was implemented to improve the quality of the referral process related to orthopedic surgery for hips and knees. This project has built a foundation of technology and clinical processes that can be built upon to expand eReferral benefits to other primary care specialist pathways.

Clinical Document Repository: The Champlain LHIN and the South East LHIN partnered in creating a Clinical Document Repository (CDR) for Eastern Ontario. The CDR is a regional repository of the key patient records that are most commonly shared among healthcare providers across the continuum of care for those patients. This is a key component in the development of an electronic health record for residents of Eastern Ontario. Future phases of the CDR project will extend the ability of the existing Eastern Ontario hospitals and physicians to share electronic clinical documents.

Base Information Technology Initiative: The LHIN has undertaken an initiative that will support the hospitals in the LHIN to implement projects that make it easier to share health records across the continuum of care. BITI initiatives are projects that will progress to allow seamless sharing of information among the hospitals of the SE LHIN. This includes steps that will integrate IT networks, user identification and user access.

Resource Matching and Referral The SE LHIN has actively engaged in this provincial initiative through membership on the RM&R Steering Committee and through partnership with the North and Eastern Ontario LHIN cluster. The LHIN has engaged with HSP's in this region to develop standard RM&R processes and forms that will inform and guide the implementation stage as the initiative develops and progresses.

9. *Expanding Culturally and Linguistically Sensitive Health-care Services*

The South East LHIN is committed to working with French language communities and the health providers serving them to ensure there is appropriate access to care in the French language. Equally, the South East LHIN will work with its Aboriginal communities to offer assistance in their efforts to ensure appropriate access to care.

Activities Supporting This Priority

Development of FLS Action Plan: Following upon last year's appointment of a full time FLS Coordinator and the subsequent appointment of Ottawa-based *Le Reseau des Services de Sante en Francais de l'Est de l'Ontario* as the French Health Planning Entity for the SE LHIN, we have progressed to the development of a Joint Action Plan with the Reseau that will guide us in expanding on the delivery of health care services in French to French-speaking residents of this region.

Engagement with Aboriginal Populations: Quarterly meetings with the SE LHIN Board Chair, CEO and staff continued throughout FY 2011/12 with the Chief and Council of the Mohawks of the Bay of Quinte with a focus on improved relationships and the identification of areas of support for their strategic plan.

In 2011-12, too, the Métis Nation of Ontario completed the health population survey for all MNO residents of this region. The results of the survey will assist in identifying priorities and informing the development of the IHSP3.

10. *Advancing System Improvement Through Boards Working Together*

The role of health-care governance is evolving in the LHIN environment, where boards are not just responsible for overseeing the management of their own organization, but also for contributing to the development and functioning of an integrated system of care. The South East LHIN will continue to nurture an environment where Boards are working together to lead and support integration and system development.

Activities Supporting This Priority

Collaborative Governance: As part of its determination to strengthen collaborative governance and working relationships with Health Service Providers across the south east, the SE LHIN Board has finalized membership of a recently-formed Collaborative Governance & Community Engagement (CGCE) Committee of the Board.

The committee will seek to engage with HSP partners in developing good governance principles of integration, collaboration, systems thinking, quality care and patient safety in ways that will achieve tangible progress within all sectors of the south east health care delivery system. Whether by helping to coordinate a system-wide approach to health planning, or paving the way for integration initiatives, the Collaborative Governance & Community Engagement Committee will look for ways to establish a common platform on which the Boards of Health Service Providers can work closely and effectively with the LHIN Board in improving access to quality care for residents of the region.

The sectors to be represented on this new committee will include Community Support, Public Health, Long Term Care, Community Health Centres, Other Primary Care providers, Hospitals, the CCAC, Mental Health and Addictions, Academia and the community at large.

The CGCE Committee also includes representatives from the SE LHIN to sit as Co-Chairs, ex-officio members and resource staff.

SE LHIN Accreditation Canada Designation: A survey last Fall of the SE LHIN's Board governance and staff operations by Accreditation Canada earned the LHIN a full Accreditation that speaks in glowing terms about the direction and accomplishments of this organization.

In their survey report Accreditation Canada found that *"The board of directors demonstrates overall accountability for ensuring the development and implementation of an integrated health care system that provides accessible, high-quality and sustainable care within the resources available."* The report further states that *"Community partners describe a strong two-way working relationship with the LHIN....*and that...*"The LHIN is perceived as being 'keen on improving' and 'ahead of the curve' according to external stakeholders."*

The South East LHIN is the first LHIN in the province to have been surveyed and earn full Accreditation from Accreditation Canada, and we were gratified to see observations in the report such as, *"Staff are deeply committed and proud of their work. They describe 'constantly LEANing' to bring about further efficiencies and business process improvements. Commendation is given to the many examples of techniques and approaches in engaging the community, which include the process to define the vision and strengthening primary care paths for clients to help them navigate a complex health system."*

The South East LHIN Knowledge Management Team

The Knowledge Management team is the intelligence, the eyes and the ears of the South East LHIN. It gathers, and provides thoughtful analysis of, key health indicators and trends upon which the LHIN can make solid, valid decisions regarding programs that merit additional support or gaps that must be closed.

The Knowledge Management team does this by developing and managing regional health and other related databases; assessing and reporting on key performance indicators; providing analytical leadership on a variety of projects; and collaborating with HSPs and other stakeholders.

The main activities of the Unit during fiscal 2011-2012 include:

Database/System Development and Management: The Knowledge Management Team focused locally and internally in database development to assist in ongoing measurement and monitoring activities at the LHIN. The prospect of Community Health Centre data to be available as a routine and reliable resource for planning and performance measurement was realized locally. Additionally, the potential for this local project to serve as a pilot for incorporating this database within the provincial Intellihealth system was examined with plans to implement in the coming year. Knowledge Management finalized a report detailing the requirements and options for a regional database to improve system performance monitoring and collective planning activities. Finally, Knowledge Management played a pivotal role in the implementation of *SharePoint* intranet site at the South East LHIN. Implementation was not without challenges though the system is used to improve the flow of information between staff.

Project Support: Knowledge Management team resources continued to support the Clinical Service Roadmap initiative. Additionally, evaluation and development of a number of initiatives, both provincial and local, have included Knowledge Management staff. These include: the Data Management Evaluation Committee (DMEC) of the BSO project, Discharge Link (enhanced activation therapy for local Stroke patients), implementation and assessment of the South East LHIN Health Inequities Project, and support to the provincial Primary Care leads.

Provincially, Knowledge Management staff were instrumental in the planning behind an *Information Management Needs* workshop designed as an educational opportunity to meet defined needs of LHIN decision support staff.

Performance Assessment: On an ongoing basis the Knowledge Management team developed and monitored the key performance indicators that are the yard sticks by which MLPA, StockTake, HSAA, MSAA and LSAA reports measure and assess the main performance activities in 2011/12.

SOUTH EAST LHIN PERFORMANCE INDICATORS
2011/12 ANNUAL REPORT
May 14, 2012 Release

PI No.	Performance Indicator	LHIN 2011/12 Starting Point	LHIN 2011/12 Performance Target	Most Recent Quarter 2011/12 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result
Emergency Room/Alternate Level of Care						
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	14.78%	9.46%	10.20%	7.8%	11.87%
2	90th Percentile ER Length of Stay for Admitted Patients	26.82	22.90	25.50	11.4%	25.30
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	6.88	6.80	6.83	0.5%	6.88
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.02	4.00	4.27	6.7%	4.27
Surgical Wait Times						
5	90th Percentile Wait Times for Cancer Surgery	51	51	55	7.8%	52
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	51	51	45	-11.8%	47
7	90th Percentile Wait Times for Cataract Surgery	112	97	101	4.1%	113
8	90th Percentile Wait Times for Hip Replacement	141	141	127	-9.9%	127
9	90th Percentile Wait Times for Knee Replacement	145	145	134	-7.6%	135
Diagnostic Wait Times						
10	90th Percentile Wait Times for Diagnostic MRI Scan	94	72	54	-25.0%	72
11	90th Percentile Wait Times for Diagnostic CT Scan	22	22	24	9.1%	21
Excellent Care for All/Quality						
12	Readmission within 30 Days for Selected CMGs**	15.36%	14.30%	18.71%	30.8%	17.13%
Mental Health and Substance Abuse						
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	16.80%	16.00%	19.94%	24.6%	20.13%
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	20.90%	19.90%	18.42%	-7.4%	16.64%
Access to Community Care						
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	28.00	26.60	22.00	-17.3%	23.00

* A negative percentage means the LHIN is below its target

** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability

*** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability

The above table provides the available results of key performance indicators in the Ministry-LHIN Performance Agreement (MLPA) for the 2011/12 fiscal period. For the majority of priority surgical and DI procedures (including cardiac by-pass, hip and knee surgeries and CT/MRI diagnostic scans) the LHIN has achieved the expected regional wait time targets. Monitoring and sustaining these levels will remain as an important priority for the 2012/13 period.

LHIN Commentary on Performance Indicator Results

Other key performance indicators in the MLPA have tended to fluctuate around desired targets. Each of these indicators are presented below along with a review and steps to address gaps in performance.

Cataract Surgery Wait Time 90th Percentile Wait (days))	Target		LHIN Start	QuarterlyPerformance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	182	97	112	126	112	108	101	113

Cataract Wait Times – Starting with a LHIN baseline of 112 days, the 90th percentile wait time for completed cataract surgery procedures peaked early in the fiscal year and reduced steadily to around 101 days at the end of the year. The SE LHIN remains well below the provincial target. A regional MOU related to Ophthalmology Surgical is now been developed. The goal of the MOU will be to support a Regional System of Integrated Ophthalmology Care in the SE LHIN and to ensure patients receive timely and appropriate Ophthalmological care within the SE region.

Cancer Surgery Wait Time 90th Percentile Wait (days)	Target		LHIN Start	QuarterlyPerformance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	84	51	51	54	49	47	55	52

Cancer Surgery Wait Times – The 90th percentile wait time target for Cancer surgery was set to 51 days at the beginning of the fiscal period. The SE LHIN achieved a performance level of 52 days on this indicator. This well below the provincial target (84 days) and performance remained better than provincial levels over each quarter of the fiscal year. The SE LHIN will continue to work with Cancer Care Ontario and our local hospitals to monitor surgical wait times related to cancer.

Readmissions for Selected CMGs % readmitted within 30 days	Target		LHIN Start	QuarterlyPerformance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	TBD	14.3%	15.4%	17.6%	18.7%	NA	NA	17.1%

Readmission within 30 days for Selected CMGs – The percentage of cases readmitted within 30 days continues to increase. It is important to note there is a substantial time lag between when the estimates are reported and when LHIN interventions can be applied. GI and COPD have been identified as the two major contributors based on patient volumes; CHF and diabetes however have the highest readmission rates based on eligible clinical cohorts. Also from a volumes perspective the two largest SELHIN facilities (KGH and QHC) accounted for about 70% of readmissions even though one of the smaller community hospitals (LACGH) tended to record a notably higher readmission rate. Across the SELHIN there are various initiatives currently in place or being planned to reduce the overall readmission rate and this continues to be a LHIN priority.

Repeat ER visits for MH conditions % with follow up within 30 days	Target		LHIN Start	QuarterlyPerformance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	TBD	16.0%	16.8%	20.1%	19.9%	NA	NA	20.1%

Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions – The percentage of cases was slightly higher than provincial percentages throughout the year. Initiatives to influence this target have been tied to Clinical Services Roadmap (CSR) work. While the performance continues to fluctuate due to small numbers of patients, it must be recognized that there are a few repeat patients who contribute to the recidivism rates. Five mental health and addictions initiatives have been identified that should influence this target (BSS, ED, Coordinated Intake, HHR, HSRC). Much of this work requires community and hospital collaboration to effect change. It is expected that implementation of a regional coordinated intake and BSS implementation are best positioned to influence this target.

Admitted Patients 90th Percentile Wait (hours)	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	25*	22.9	26.8	24.2	27.1	24.1	25.5	25.3

Non-admitted Complex patients 90th Percentile Wait (hours)	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	8	6.8	6.9	6.8	7.1	6.8	6.8	6.9

Non-admitted Uncomplicated pts. 90th Percentile Wait (hours)	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	4	4	4.0	4.2	4.4	4.1	4.3	4.3

90th Percentile Emergency Room Length of Stay by Patient Category – The ER Length-of-Stay for each patient category was above the LHIN target. For non-admitted complex (CTAS I-III) and minor/uncomplicated (CTAS IV-V) patients the LHIN performance fluctuated close to the target but the wait time remained shorter than provincial performance levels. For admitted patients performance is even better when compared to provincial levels but locally this patient group remains the most difficult group to impact. The LHIN and all hospitals across the SE LHIN will continue to reduce ER LOS through the CSR ED Wait time initiatives: Bed Management/Clinical Utilization and Improved Access to specialized care.

Percentage of ALC Days % of Total Acute Inpatient Days	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	9.46%	9.46%	14.78%	10.35	12.96	10.20	NA	11.87%

Percentage of Alternate Level of Care (ALC) Days – The percentage total days that are 'Alternate Level of Care' (ALC) continues to drop in the South East LHIN. The 10.2% ALC mark realized in Q3 is the lowest %ALC measured across SE LHIN Institutions. Programs targeting this patient population continue to be refined and implemented across the region

SE LHIN Operational Performance

Funding Allocation
Total: $6,547,019
Base: $4,782,269
Project: $1,764,750

South East LHIN management administered an allocation of $6,547,019 in fiscal year 2011/12. The allocation is comprised of the LHIN's total corporate operational budget of $4,782,270 along with special ancillary project-based funding totaling $1,764,750.

Ancillary Project-Based Funding

The LHIN received special funding for projects supporting Ministry of Health and Long-Term Care health system priorities, as well as the LHIN's Integrated Health Services Plan *"Priorities for Change"*. These projects included:

- e-Health Project Management Office†
- Behavioural Supports Ontario
- Emergency Room / Alternative Level of Care Strategy†
- Emergency Department Initiative
- Aboriginal Community Engagement Initiative
- French Language Services Initiative†
- Critical Care Initiative
- Primary Care Initiative

† A Ministry of Health and Long-Term Care condition of funding is the selection of an individual to lead each of these projects. Project leads are provided with work space within the LHIN offices.

Accreditation Canada

As noted under IHSP2 Priority Ten (*"Advancing System Improvement Through Boards Working Together"*) earlier in this Annual Report, the SE LHIN has earned full accreditation from Accreditation Canada – becoming the first LHIN in the province to do so.

2011/12 Audited Financial Statements

An external audit was conducted by Deloitte & Touche LLP in April 2012. A copy of the auditor's report is provided in the following section of this document. The results of the audit for the 2011/2012 fiscal year were very positive. The South East LHIN ended the fiscal year in a balanced financial position.

Statutory Compliance – Ontarians With Disabilities Act, 2001

Pursuant to direction from the Accessibility Directorate of Ontario, the South East LHIN has met its obligations under statute and has ensured that Ontarians with disabilities have access to our facilities, services, and information made available to the public.

Financial statements of

South East Local Health Integration Network

March 31, 2012

South East Local Health Integration Network

March 31, 2012

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Independent Auditor's Report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the accompanying financial statements of the South East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2012, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 28, 2012

South East Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**1,674,708**	1,373,084
Accounts receivable (Note 3)	**57,001**	65,589
	1,731,709	1,438,673
Liabilities		
Accounts payable and accrued liabilities (Note 4)	**1,121,742**	815,436
Due to MOHLTC and eHealth Ontario (Note 5)	**347,744**	302,497
Due to the LHIN Shared Services Office (Note 7)	**-**	19,552
Deferred capital contributions (Note 8)	**505,585**	621,198
Obligations under capital lease (Note 16)	**290,568**	315,807
	2,265,639	2,074,490
Net debt	**(533,930)**	(635,817)
Non-financial assets		
Prepaid expenses	**28,345**	14,619
Capital assets (Note 9)	**505,585**	621,198
	533,930	635,817
Accumulated surplus	**-**	-

Approved by the Board:

Wynn Turner
Board Chair

Ian Fraser
Audit Committee Chair

South East Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (unaudited) (Note 10)	2012 Actual	2011 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 11)	984,696,442	1,070,700,326	1,017,913,350
Operations of LHIN (Notes 5, 10 and 12)	4,782,269	4,778,389	4,302,588
e-Health (Note 6a)	-	600,000	1,325,000
Emergency Department (Note 6b)	-	75,000	75,000
Aboriginal Initiative (Note 6c)	15,000	15,000	15,000
ER/ALC Initiative (Note 6d)	-	100,000	100,000
French Language Services Initiative (Note 6e)	106,000	106,000	110,000
Critical Care Initiative (Note 6f)	-	75,000	75,000
Primary Care Initiative (Note 6g)	-	43,750	-
Behavioural Support Ontario (Note 6h)	-	750,000	-
Amortization of deferred capital contributions (Note 8)	-	119,491	147,905
	989,599,711	1,077,362,956	1,024,063,843
Funding repayable to the MOHLTC and eHealth Ontario (Note 5a)	-	(347,744)	(302,497)
	989,599,711	1,077,015,212	1,023,761,346
Expenses			
Transfer payments to HSPs (Note 11)	984,696,442	1,070,700,326	1,017,913,350
General and administrative (Note 12)	4,782,269	4,895,501	4,447,604
e-Health (Note 6a)	-	569,907	1,039,120
Emergency Department (Note 6b)	-	66,110	73,937
Aboriginal Initiative (Note 6c)	15,000	15,000	15,000
ER/ALC Initiative (Note 6d)	-	100,000	100,000
French Language Services Initiative (Note 6e)	106,000	102,844	99,310
Critical Care Initiative (Note 6f)	-	72,912	73,025
Primary Care Initiative (Note 6g)	-	18,985	-
Behavioural Support Ontario (Note 6h)	-	473,627	-
	989,599,711	1,077,015,212	1,023,761,346
Annual surplus and closing accumulated surplus	-	-	-

South East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012 $	2011 $
Annual surplus	-	-
Acquisition of capital assets	(3,878)	(479,682)
Amortization of capital assets	119,491	147,905
Increase in prepaid expenses	(13,726)	(8,695)
Decrease (increase) in net debt	101,887	(340,472)
Opening net debt	(635,817)	(295,345)
Closing net debt	(533,930)	(635,817)

South East Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**119,491**	147,905
Amortization of deferred capital contribution (Note 8)	**(119,491)**	(147,905)
Changes in non-cash operating items		
Decrease (increase) in accounts receivable	**8,588**	(65,589)
Decrease in due from LHIN Shared Services Office	-	1,895
Increase in prepaid expenses	**(13,726)**	(8,695)
Increase (decrease) in accounts payable and accrued liabilities	**306,306**	(38,712)
Increase in due to MOHLTC and eHealth Ontario	**45,247**	173,750
Increase (decrease) in due to the LHIN Shared Services Office	**(19,552)**	19,552
	326,863	82,201
Capital transaction		
Acquisition of capital assets	**(3,878)**	(479,682)
Financing transactions		
Increase in deferred capital contributions (Note 8)	**3,878**	479,682
Increase in obligations under capital lease	-	319,178
Repayment of obligations under capital lease	**(25,239)**	(3,371)
	(21,361)	795,489
Net change in cash	**301,624**	398,008
Cash, beginning of year	**1,373,084**	975,076
Cash, end of year	**1,674,708**	1,373,084

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the South East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into a Performance Agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN is home to over 489,600 people, which encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("Performance Agreement"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2012.

The LHIN statements do not include any Ministry managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

2. Significant accounting policies (continued)

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and losses in the book value of assets.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Maintenance and repair costs are recognized as an expense when incurred. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized, on a straight line basis, over their estimated useful lives as follows:

Office equipment	5 years
Computer equipment	3 years
Infrastructure/Web developments	3 years
Leasehold improvements	Life of lease

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of financial activities and within the related notes for both the prior and current year sufficiently disclosed information of all appropriate segments and, therefore, no additional disclosure is required.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the capital assets. Actual results could differ from those estimates.

3. Accounts receivable

The LHIN at March 31, 2012 has accounts receivable of $57,001 which primarily represent HST receivable for the last quarter of the fiscal year.

4. Accounts payable and accrued liabilities

At March 31, 2012 the LHIN has accounts payable and accrued liabilities valued at $1,121,742. This amount represents $441,023 in accounts payable and $680,719 in accrued liabilities.

5. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the Performance Agreement, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the eHealth Ontario.

In accordance with the accounting policy related to deferred capital contributions (Note 2) the LHIN has recognized the amortization of deferred capital contributions of $119,491 (2011 - $147,905) as revenue. This has resulted in an increase to the overall LHIN Operations revenue as shown in the table below. LHIN Operations base funding for 2012 after adjustments was $4,782,269 as detailed in Note 10.

(a) The amount repayable to the MOHLTC is made up of the following components:

			2012
	Funding received	Related expenses	Excess funding
	$	$	$
Transfer payments to HSPs	1,070,700,326	1,070,700,326	-
LHIN operations	4,897,880	4,895,501	2,379
E-Health	600,000	569,907	30,093
Emergency department initiative	75,000	66,110	8,890
Aboriginal initiative	15,000	15,000	-
ER/ALC Initiative	100,000	100,000	-
French Language Services Initiative	106,000	102,844	3,156
Critical Care Initiative	75,000	72,912	2,088
Primary Care Initiative	43,750	18,985	24,765
Behavioural Support Ontario	750,000	473,627	276,373
	1,077,362,956	1,077,015,212	347,744

5. Funding repayable to the MOHLTC and eHealth Ontario (continued)

(b) The amount due to the MOHLTC at March 31 is made up as follows:

	2012	2011
	$	$
Opening balance	**302,497**	128,747
Funding repaid during the year	**(302,497)**	(128,747)
One-time funding repayable to the MOHLTC	**315,272**	299,608
LHIN Operations funding repayable to MOHLTC	**2,379**	2,889
Closing balance	**317,651**	302,497

(c) The amount due to the eHealth Ontario at March 31 is made up as follows:

	2012	2011
	$	$
Due to eHealth Ontario, beginning of year	**-**	-
Paid to eHealth Ontario during year	**-**	-
Funding repayable to the eHealth Ontario realted to current year activities (Note 5a)	**30,093**	-
Due to eHealth Ontario, end of year	**30,093**	-

6. a) e-Health Initiative

During fiscal 2012, the LHIN received funding in the amount of $600,000 ($1,325,000 in 2011 from MOHLTC - $600,000 for Project Management Office, $450,000 for Implementation and adoption and $275,000 for Provincial Coordinator) from the eHealth Ontario for Project Management Office. These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan. Unspent funds, amounting to $30,093 ($285,880 in 2011) at year end, are repayable to eHealth Ontario (MOHLTC in 2011).

	2012	2011
	$	$
Expenses		
Salaries and benefits	**308,860**	488,322
Consulting services	**126,775**	388,309
Travel	**15,308**	22,667
Meeting expenses	**3,345**	11,306
Accomodations	**-**	17,077
Shared services	**-**	31,956
Other	**115,619**	79,483
	569,907	1,039,120

6. (continued)

b) Emergency Department Initiative

During fiscal 2012, the LHIN received funding in the amount of $75,000 ($75,000 in 2011) from the MOHLTC. These funds were used toward initiatives in support of the strategic Emergency Department Initiative and fell under the Access to Specialized Medical Services, within the Integrated Health Services Plan "Priority for Change". Unspent funds, amounting to $8,890 ($1,063 in 2011) at year end, are repayable to the MOHLTC.

	2012	2011
	$	$
Expenses		
Salaries and benefits	**63,300**	67,500
Travel	**-**	2,155
Other	**2,810**	4,282
	66,110	73,937

c) Aboriginal Initiative

During fiscal 2012, the LHIN received funding in the amount of $15,000 ($15,000 in 2011) from the MOHLTC. These funds were used toward planning and engagement with the Aboriginal community in support of the Integrated Health Services Plan "Priority for Change".

	2012	2011
	$	$
Expense		
Other	**15,000**	15,000
	15,000	15,000

d) ER/ALC Initiative

During fiscal 2012, the LHIN received funding in the amount of $100,000 ($100,000 in 2011) from the MOHLTC. These funds were used in support of the ER/ALC Strategy.

	2012	2011
	$	$
Expense		
Salaries and benefits	**100,000**	100,000
	100,000	100,000

Actual expenditures incurred as part of the ER/ALC Initiative activities were in excess of the $100,000 funding provided by the MOHLTC. The total of actual expenses is $147,100 ($136,754 in 2011). The overage of $47,100 ($36,754) has been funded through LHIN Operations base.

	2012	2011
	$	$
Expenses		
Salaries and benefits	**135,594**	126,593
Travel	**5,762**	7,068
Meeting expenses	**1,366**	433
Other	**4,378**	2,660
	147,100	136,754

6. **(continued)**

e) French Language Services Initiative

During fiscal 2012, the LHIN received funding in the amount of $106,000 ($110,000 in 2011) from the MOHLTC. These funds were used in support of the French Language Services Strategy. Unspent funds, amounting to $3,156 (10,690 in 2011) at year end, are repayable to the MOHLTC.

	2012	2011
	$	$
Expenses		
Salaries and benefits	**82,663**	62,345
Consulting services	**-**	11,535
Travel	**4,564**	4,377
Meeting expenses	**113**	-
Accomodations	**-**	4,269
Shared services	**-**	7,989
Other	**15,504**	8,795
	102,844	99,310

f) Critical Care Initiative

During fiscal 2012, the LHIN received funding in the amount of $75,000 ($75,000 in 2011) from the MOHLTC. These funds were used in support of the Critical Care Strategy. Unspent funds, amounting to $2,088 ($1,975 in 2011) at year end, are repayable to the MOHLTC.

	2012	2011
	$	$
Expenses		
Salaries and benefits	**72,000**	72,000
Travel	**912**	1,025
	72,912	73,025

g) Primary Care Initiative

During fiscal 2012, the LHIN received in-year funding in the amount of $43,750 (Nil in 2011) from the MOHLTC. These funds were used toward planning and engagement with Primary Health Care providers in support of the Integrated Health Services Plan "Priority for Change." Unspent funds, amounting to $24,765 (Nil in 2011) at year end, are repayable to the MOHLTC.

	2012	2011
	$	$
Expenses		
Salaries and benefits	**18,000**	-
Travel	**970**	-
Other	**15**	-
	18,985	-

6. (continued)

h) Behavioural Support Ontario (BSO)

During fiscal 2012, the LHIN received in-year funding of $750,000 (Nil in 2011) as an Early Adopter LHIN to implement the BSO framework. The BSO Project was created to enhance services for Ontarians in support of the Integrated Health Services Plan. Unspent funds, amounting to $276,373 (Nil in 2011) at year end, are repayable to the MOHLTC.

	2012	2011
	$	$
Expenses		
Salaries and benefits	**303,586**	-
Consulting services	**26,350**	-
Travel	**3,528**	-
Meeting expenses	**6,715**	-
Other	**133,448**	-
	473,627	-

7. Related party transactions

LHIN Shared Services Office (LSSO)

The LSSO is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

LHIN Collaborative (LHINC)

LHINC was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- their role as system manager;
- where appropriate, the consistent implementation of provincial strategy and initiatives;
- the identification and dissemination of best practices.
- LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the Ministry of Health and Long-Term Care.

LHINC is a division of Toronto Central LHIN and as such is subject to the same policies, guidelines and directives as the Toronto Central LHIN.

8. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	**621,198**	289,421
Capital contributions received during the year	**3,878**	479,682
Amortization for the year	**(119,491)**	(147,905)
Balance, end of year	**505,585**	621,198

9. Capital assets

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment	**408,007**	**200,719**	**207,288**	279,064
Computer equipment	**122,406**	**110,667**	**11,739**	19,756
Leasehold improvements	**358,197**	**71,639**	**286,558**	322,378
	888,610	**383,025**	**505,585**	621,198

10. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2011. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirement. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,070,700,326 is made up of the following:

	$
Initial HSP funding budget	**984,696,442**
Adjustment due to announcements made during the year	**86,003,884**
Total HSP funding budget	**1,070,700,326**

The total operating budget of $4,782,269 is made up of the following:

	$
Initial budget	**4,782,269**
Additional funding received during the year	**-**
Total budget	**4,782,269**

11. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,070,700,326 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2012	2011
	$	$
Operation of Hospitals	**703,298,709**	676,287,800
Grants to compensate for Municipal Taxation - Public Hospitals	**190,725**	190,725
Long-Term Care Homes	**170,862,497**	157,270,059
Community Care Access Centres	**102,084,846**	96,933,755
Community Support Services	**29,121,695**	27,468,705
Assisted Living Services in Supportive Housing	**2,043,566**	2,003,991
Community Health Centres	**22,200,869**	18,371,448
Community Mental Health Addictions Program	**40,897,419**	39,386,867
	1,070,700,326	1,017,913,350

12. General and administrative expenses

(a) The Statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object, as follows:

	2012	2011
	$	$
Program based		
Salaries	**3,546,649**	3,220,198
Consulting and LHIN-based projects	**46,194**	66,270
	3,592,843	3,286,468
Shared services	**435,080**	317,153
Collaborative	**26,971**	50,000
Other (details listed below)	**205,855**	198,604
Occupancy	**212,698**	118,505
Office equipment and supplies	**132,588**	106,674
Board per diem	**71,400**	132,270
Public relations	**52,123**	40,756
Mail, courier and telecommunications	**46,452**	49,269
	4,776,010	4,299,699
Amortization	**119,491**	147,905
	4,895,501	4,447,604

12. General and administrative expenses (continued)

(b) The breakdown of "Other" general and administrative expenses listed in the table above are:

	2012	2011
	$	$
Training and development	**52,829**	45,876
Travel	**111,507**	124,462
Recruitment	**10,622**	2,089
Insurance	**17,768**	17,640
Other miscellaneous	**13,129**	8,537
	205,855	198,604

(c) The total expenses related to governance is as follows, and are included in the expenses listed in Note 12(a) above:

	2012	2011
	$	$
Board chair per diems	**34,500**	86,025
All other per diems	**36,900**	46,245
Total per diems	**71,400**	132,270
Other administrative costs	**53,797**	98,885
Total governance expenditures	**125,197**	231,155
Overhead - salaries, benefits, accommodations and shared services	**153,519**	151,253
Total governance related costs	**278,716**	382,408

(d) The total occupancy and shared service costs are reduced in Note 12(a) above, due to partial cost sharing with ancillary funded projects for project staff who utilize office space and or shared services during the year. Reference Note 6 related to additional accommodations and shared services cost allocation.

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 29 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $279,712 (2011 - $261,295) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2011. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration* Act.

15. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due under the building lease as follows:

	$
2013	224,064
2014	224,064
2015	224,064
2016	224,064
2017	224,064
Thereafter	877,584
	1,997,904

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2012, the LHIN had signed Performance Agreements with all Hospitals and Community Agencies for the next one to three years dependent upon the specific sector. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

16. Obligations under capital lease

The LHIN has a lease under the provision of capital lease of leasehold improvements with a total carrying value in these statements of $255,342. The cost of this lease is included in property, plant and equipment and the related liabilities are included in long-term debt to reflect the effective acquisition and financing of these items. The lease on the building expires in February, 2021.

The present value of future minimum rentals are as follows:

	$
2013	40,456
2014	40,456
2015	40,456
2016	40,456
2017	40,456
Thereafter	158,453
Future minimum lease payments	360,733
Less: amount representing interest	(70,165)
Present value of future minimum rentals	290,568

16. Obligations under capital lease (continued)

Principal payments required on this long-term debt for the next five years are as follows:

	$
2013	26,530
2014	27,887
2015	29,314
2016	30,814
2017	32,390
Thereafter	143,633
	290,568

Map of the South East LHIN region